

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in copy the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be filed and an once

1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 850615

1. DECEASED NAME (TYPE OR PRINT)			FIRST RUTH	MIDDLE E.	LAST TACKITT FACKETT	2a. DATE OF DEATH MONTH DAY YEAR Dec. 24, 1985	2b. HOUR 5.30 P.M.										
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Dec. 24, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penns.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY		10. CITY OR TOWN OF DEATH CHEVERLY									
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY **		13a. STATE Md.		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Colmar Manor		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3408-41st Ave. 20722			
14. FATHER'S NAME Frederick		15. MOTHER'S MAIDEN NAME Maudy		16. SOCIAL SECURITY NO. 213-74-1985		17. INFORMANT Patricia Good		18. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		ADDRESS 1206-Clements Circle, Somerdale, N.J.					
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		21. DUE TO, OR AS A CONSEQUENCE OF (b)		22. DUE TO, OR AS A CONSEQUENCE OF (c)		23. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
24. MEDICAL CERTIFICATION		25. DATE OF OPERATION		26. CONDITION FOR WHICH OPERATION WAS PERFORMED		27a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		27b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
28. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		29. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		31. AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		32. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		33. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
34. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 12-24-1985 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		35. DEGREE		36. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		37. ADDRESS		38. DATE SIGNED 2-25-85									
39. PHYSICIAN'S NAME (TYPE OR PRINT) SURESH C. GUPTA, M.D.		40. ADDRESS 3503 PERRY ST. MT. RAINIER, MD.		41. DATE REC'D. BY REGISTRAR APR 04 1985		42. REGISTRAR'S SIGNATURE Julie Swanson											
43. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		44. DATE 2/27/1985		45. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem. Arlington		46. LOCATION CITY OR TOWN		47. COUNTY		48. STATE Va.							
49. FUNERAL DIRECTOR NAME Nalley's F.H. Inc.		50. ADDRESS Mt. Rainier, Md.		51. DATE REC'D. BY REGISTRAR APR 04 1985		52. REGISTRAR'S SIGNATURE Julie Swanson											



**B**  
 TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM P. RETAIN PAGE 5 FOR YOUR FILES.  
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS.  
 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.				
1- STATE REGISTRAR			2a DATE KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR OF ESTI- DEATH MATED <input type="checkbox"/>									2b HOUR				
1 DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2c. DATE PRONOUNCED DEAD	2d. HOUR			
Walter H. Terry Jr.												2 12 1985	8:12 p.m.			
3. SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2e. DATE PRONOUNCED DEAD				
MALE		BLK		9 23 65		19 yrs.		MONTHS		DAYS HOURS MIN.		2 12 1985				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
Wash., D. C.			USA						Prince George's County, MD.							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George's General Hospital									CLERK		99999		
13a. STATE D. C.			13b. COUNTY			13c. CITY OR TOWN WASHINGTON			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3426 DIX ST., N. E.					
14. FATHER'S NAME WALTER			MIDDLE H.			LAST TERRY SR.			15. MOTHER'S MAIDEN NAME WILLETTA		LAST TOUDLE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 577 92 0264			17. INFORMANT WILLETTA BARNES			ADDRESS 3426 DIX ST., NE		WASH. D. C.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound to chest and abdomen</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> (b) DUE TO, OR AS A CONSEQUENCE OF (c)													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 4:15 A.M. 2 12 1985			21b. TIME OF INJURY HOUR AM MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject shot										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) jewelry store			21f. LOCATION STREET 9432 Lanham Severn Rd, Seabrook, P.G., MD.			CITY OR TOWN		COUNTY	STATE				
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Margarita Korell</u>													Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion			
													TITLE (SPECIFY) M.D. Assistant		DATE SIGNED 2/13/85	
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 111 Penn St. Balto. M.D.													
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 111 Penn St. Balto. M.D.													
23a. BURIAL, CREMATION REMOVAL (SPECIFY) BURIAL			23b. DATE 2/18/85			23c. NAME OF CEMETERY OR CREMATORIAL HARMONY MEM. PARK			23d. LOCATION CITY OR TOWN LANDOVER, MD.		COUNTY	STATE				
24 FUNERAL DIRECTOR NAME WATSON F. H. INC.			ADDRESS 3435 14th ST., N. W.			WASH. D. C.			25a. DATE REC'D. BY REGISTRAR FFB 20 1985		25b. REGISTRAR'S SIGNATURE <u>Lilia Davidson Korell</u>					
07/84 25N BP																
DHMH-17 (VR A15 ME (5))																



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Items 18-22a 3/5/85 mlo  
F#601STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

0 6 1

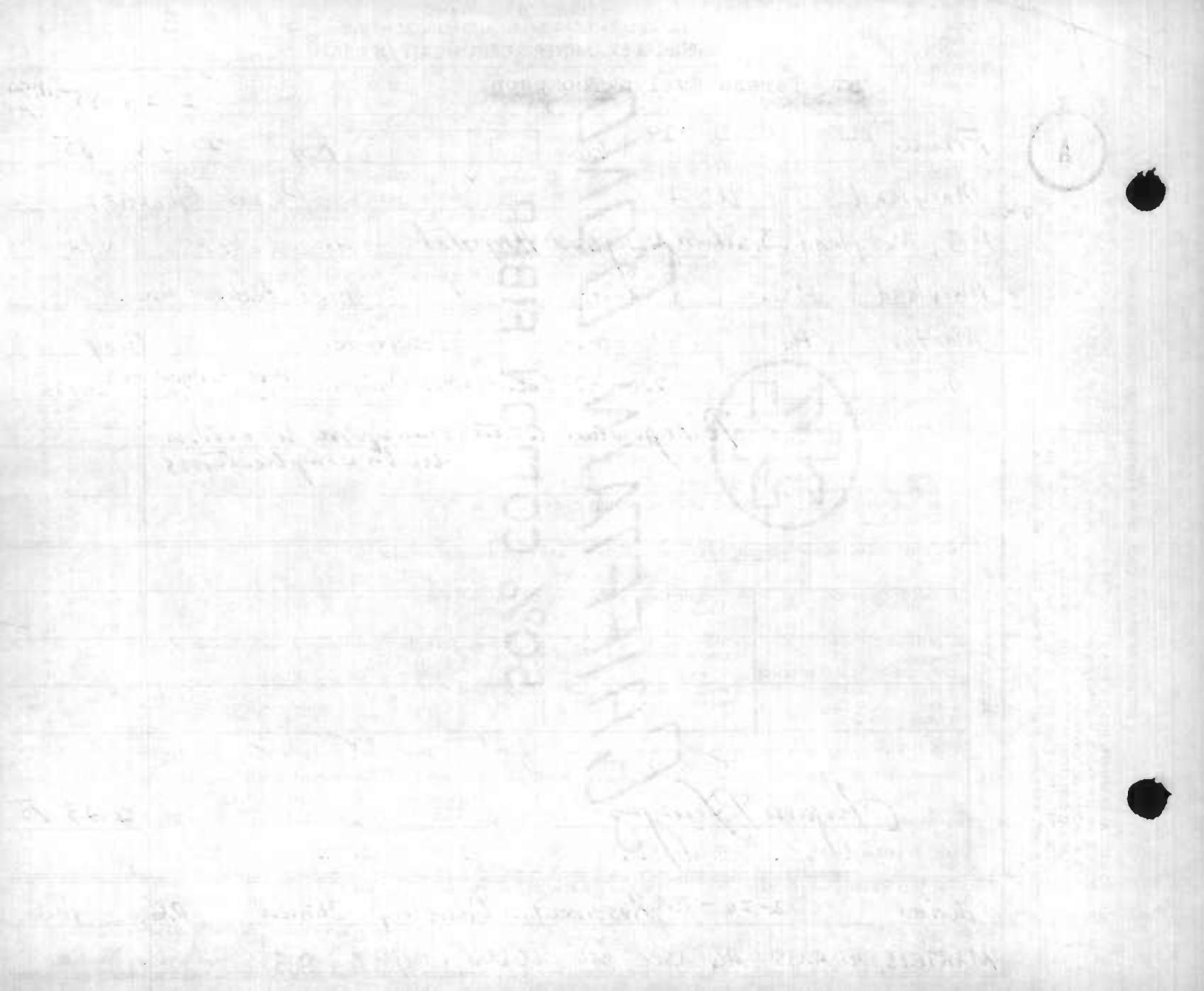
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR				
MEREDITH			ALANDUS	THOMAS		2-3-85	19		M					
SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD				2d. HOUR				
Male	Black	8 14 49	35 yrs.			2-3-85				5:11 P				
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Martinsville, Va.			USA						Prince George's County MD					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Cheverly			Prince George's Co. Hospital			Pep Co. Underground			20722					
13a. STATE Md			13b. COUNTY			13c. CITY OR TOWN Brentwood			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 4412 39th Street		
14. FATHER'S NAME FIRST James			MIDDLE Thomas			15. MOTHER'S MAIDEN NAME FIRST Myrtle			LAST Coleman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS					
No			577-66-2909			Mrs. Clara Thomas/wife/same as 13e								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														
PART 1 DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) <u>Alcoholism</u>														
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.														
(b)														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?								
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion														
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <u>Margarita A. Korell</u> TITLE (SPECIFY) <u>M.D.</u> MEDICAL EXAMINER														
EXAMINER'S NAME (TYPE OR PRINT) <u>Margarita A. Korell, M.D.</u> ADDRESS <u>111 Penn Street</u>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 2-7-85			23c. NAME OF CEMETERY OR CREMATORIAL Harmony Memorial			23d. LOCATION CITY OR TOWN Landover, Md.			COUNTY STATE		
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR John T. Rhines Co., 3015 12th St. N.E., D.C. 20017			25b. REGISTRAR'S SIGNATURE FEB 21 1985					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY NEEDS BE PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 5-7 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1AND 2 SHOULD BE TITLED WITH "DEATH" AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, NO 1 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 06118	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF EST. DEATH MATED			2b. HOUR		
Teresa Evelyn Thompson						2-23 1985			11:00 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
Female		BLK		01 14 19		66 yrs.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. NEVER MARRIED DIVORCED		10. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		USA		<input checked="" type="checkbox"/>		<input type="checkbox"/>		Prince George's			
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
P.G. Maryland		Southern Maryland Hospital				Home-maker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE 13b. COUNTY										13c. CITY OR TOWN	
Maryland		P.G.		Clinton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
14. FATHER'S NAME FIRST MIDDLE LAST										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	
Martin H. Proctor				Josephine Gray							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
NO		220-32-6285		Frances Thompson 9528 Badger Ave.		Postoperative arteriovenous fistula with complications				Clinton, Md. 20735	
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.										DUE TO, OR AS A CONSEQUENCE OF	
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?							20. AUTOPSY?	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i> TITLE <i>Deputy</i> M.D. MEDICAL EXAMINER										and in my opinion	
EXAMINER'S NAME <i>Augusto P. Rodriguez, M.D.</i> ADDRESS 5009 Rayburn Ct., Temple Hills, Md.										DATE SIGNED <i>2-23-85</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 2-26-85			23c. NAME OF CEMETERY OR CREMATORIAL Resurrection Cemetery			23d. LOCATION CITY OR TOWN Clinton		
24. FUNERAL DIRECTOR NAME <i>MARTELL ADAMS, AQUASCO, MD. 20608</i>						25a. DATE REC'D. BY REGISTRAR MAR 4 1985			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson Pendleton</i>		
07/84 25M		BP		DHMH - 17 (VR A15 ME (5))							



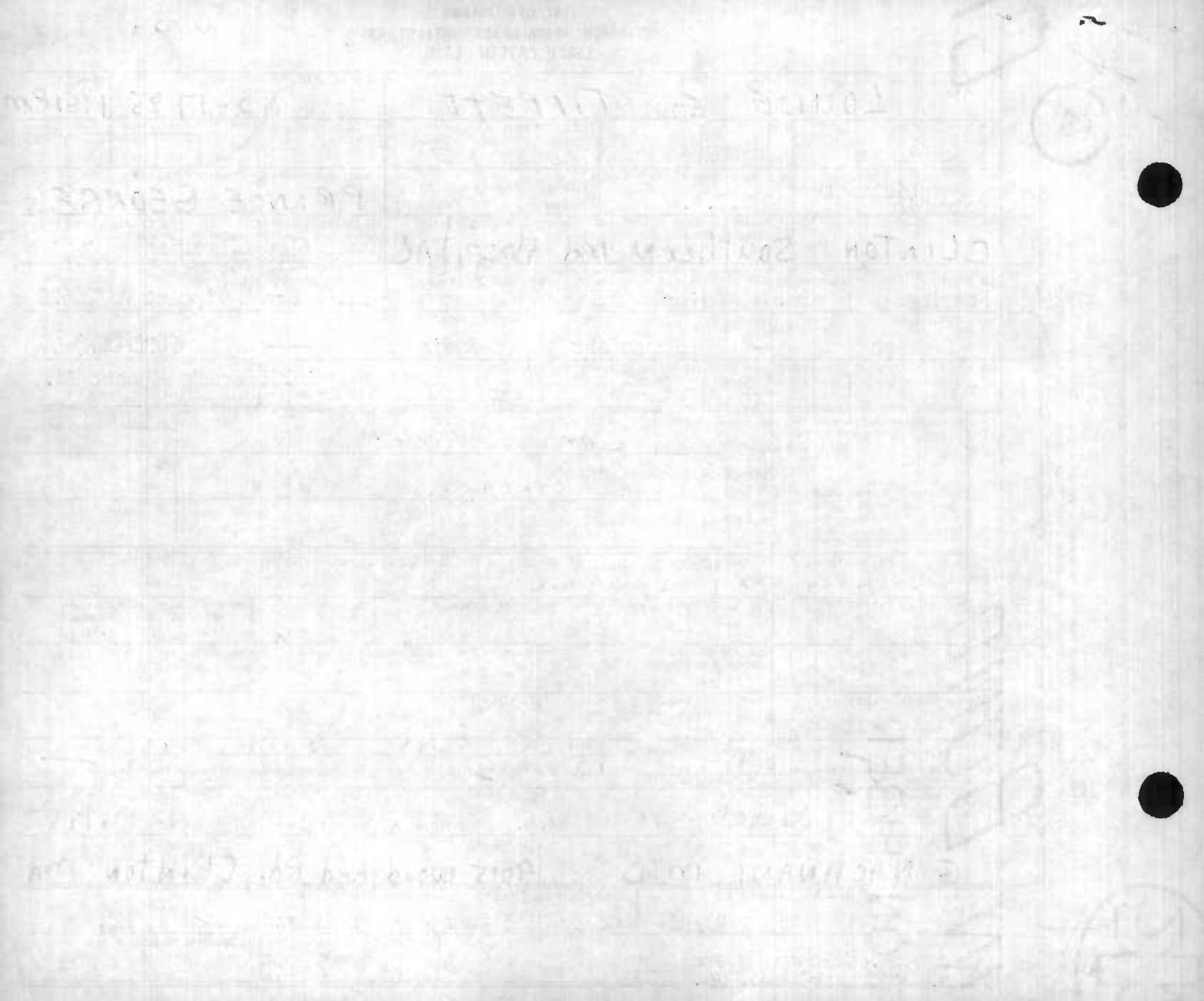
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached from this certificate and sent to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18b shows any injury, or other traumatic event, the medical examiner should be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.				
1. FOR STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
	LOUISE XEMILIE TIPPETT			02-17-85			11:51 P.M.			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Female	White	May 28, 1907			77 YRS.			MONTHS	DAYS	
7a. BIRTHPLACE COUNTRY	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 7 1/2 HRS.		
District of Columbia	U.S.A.				PRINCE GEORGE'S					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT A NURSING FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION TYPE OF WORK FOR MOST OF WORKING LIFE			12b. KIND OF BUSINESS OR INDUSTRY			
CLINTON	Southern Md Hospital			Classified Librarian (Civilian)			U. S. Navy			
13a. STATE Maryland	13b. COUNTY Pr. Geo's	13c. CITY OR TOWN Cheltenham	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 10203 Frank Tippett Rd/20623				
14. FATHER'S NAME FIRST Rudolph	MIDDLE --	LAST Schaefer	15. MOTHER'S MAIDEN NAME FIRST Lydia			MIDDLE --	LAST (UNKNOWN)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. 216-44-7636			17. INFORMANT Marilyn Stallings-			ADDRESS 10203 Frank Tippett Rd., Cheltenham, Md. 20623			
No										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEPATIC COMA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>LIVER CIRRHOSIS</u> . Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <u>URINARY TRACT INFECTION</u>										
19a. DATE OF OPERATION --	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED --			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1115, 1985, to 2117, 1985, that (I) (we) lost saw the deceased alive on 2117, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>G. Nachani</u>	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 218/85							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. NACHANI M.D.	22e. ADDRESS 9015 woodyard Rd, Clinton md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 2/21/85	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery	23d. LOCATION CITY OR TOWN Suitland(Pr. Geo's) Md.			COUNTY			STATE	
24. FUNERAL DIRECTOR NAME Richard A. Coleman Funeral Home, Upper Marlboro, Md. 20772	25a. DATE REC'D. BY REGISTRAR FEB 22 1985			25b. REGISTRAR'S SIGNATURE <u>Richard A. Coleman</u>						
BP _____										
DHMH - 16 50M 4/83 (VRA 15, 4)										



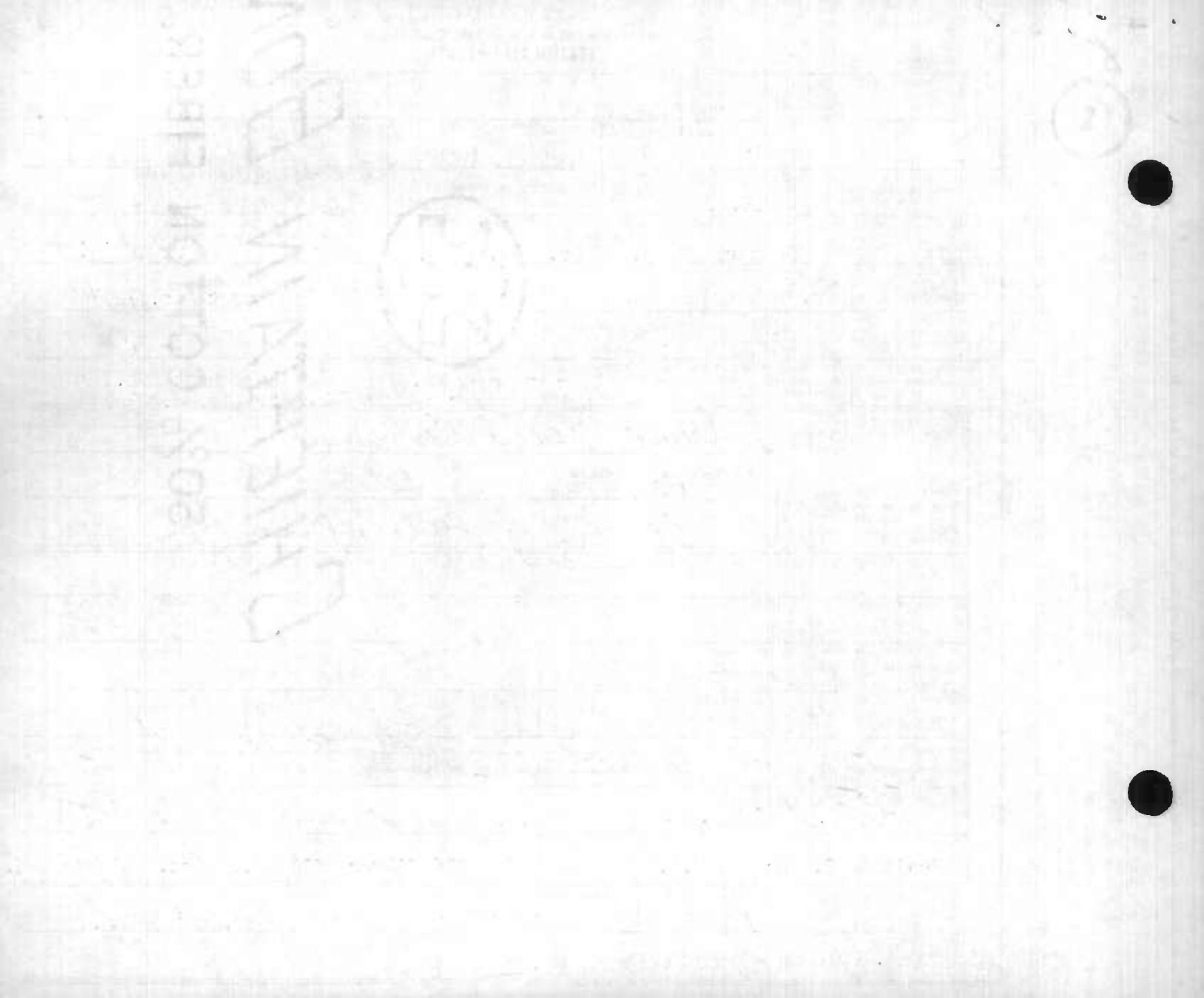
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon adapter. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as Item 18 shows any injury, or either traumatic event, the medical examiner must be notified at this time.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8506120			
					REG. NO.			
1. FOR STATE REGISTRAR	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	February 18, 1985			8:05p.m.	
Roscoe Ward TIPPETT								
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male	White	April 1, 1917			67	YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH	
District of Columbia	U.S.A.						Prince George's County MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Lanham	Doctors' Hosp. of Pr. Geo.'s Co.			Clerk			S. Treasury Dept.	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE		
Maryland	Pr. Geo's	Forestville	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			2602 Lakehurst Ave., /20747		
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME				
J. Hammond			Tippett	Clara A. Cooke				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS	
No	-----			Mazie D. Tippett			2602 Lakehurst Ave., Forestville, Md. 20747	
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)								
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma of prostate</i> (c) <i>Carcinoma of recto sigmoid colon</i>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IE EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>	21e. PLACE OF INJURY AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.	21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that this hospital attended the deceased from <u>now the deceased died on</u> <u>1985</u> , to <u>1985</u> , that (I) (we) last saw the deceased alive on <u>1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) allow the body after death.								
22b. SIGNATURE	22c. DEGREE			22d. DATE SIGNED				
<i>Benjamin S. Pecson</i>	M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22e. DATE SIGNED			
22e. ADDRESS	6106 Old Silver Hill Rd., Dist. Heights, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN	23e. COUNTY	23f. STATE	
Burial	2/22/85	Cedar Hill Cemetery			Suitland (Pr. Geo's)	Md.	20028	
24. FUNERAL DIRECTOR	25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Richard A. Coleman -Upper Marlboro, Md. 20772 Funeral Home	FEB 22 1985			John W. Anderson				



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5 06121

1- STATE REGISTRAR	REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)	FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED	2b. MONTH MONTH	2c. DAY DAY	2d. YEAR YEAR
Adelina	Teresa			ssetti						<input checked="" type="checkbox"/>	2-2	1985	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. MARRIED WIDOWED	10. CITIZEN OF WHAT COUNTRY?	11. DATE PRONOUNCED DEAD	12. BALTIMORE CITY OR COUNTY OF DEATH	12a. DATE MONTH	12b. DAY DAY	12c. HOUR YEAR	
Female	White	6-6-95 89	YRS.	MONTHS	DAYS	HOURS	USA	2-2	1985	11:30	M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED WIDOWED	9. BALTIMORE CITY OR COUNTY OF DEATH										
ITALY	USA	<input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED	Prince Georges										
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN A NURSING FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK) FOR MOST OF WORKING LIFE					12b. KIND OF BUSINESS OR INDUSTRY		
CLINTON	Southern Maryland Hospital					HOUSEWIFE					OWN HOME		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS									
MARYLAND	P.G.	CLINTON	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	5601 Gwynndale Place									
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST								
Carlo		Narcisi	Filomena		Marinozza								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS										
NO	577-84-1934	Maragret DiGennaro	same as 13										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause lost.													
(b) DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE								
22a. I certify that I took charge of the remains described above, held on <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i> TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER													
DATE SIGNED <i>2-3-85</i>													
EXAMINER'S NAME <i>Augusto P. Rodriguez, M.D.</i> ADDRESS 5009 Rayburn Ct., Temple Hills, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION CITY OR TOWN	23e. COUNTY	23f. STATE								
Burial	6FEB85	Cedar Hill Cemetery	Suitland	PG	MD								
24. FUNERAL DIRECTOR NAME	ADDRESS	Suitland	25a. DATE OF RECORD FEB 1 1985	25b. REG. NO.	25c. REG. NO.								
Robert E Wilhelm Funeral Home	MD												

CHIATORO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked NO, then there was no injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

0 5 0 6 1 2 2  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
			HELEN	P.	TOPMILLER	02-15-85				6:45AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
Female		White		3 12 1903		81		MONTHS		DAYS	
9. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
Massachusetts		U.S.A.				PRINCE GEORGE'S COUNTY		CHEVERLY		PRINCE GEORGE'S GENERAL HOSPITAL	
12. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		12b. KIND OF BUSINESS OR INDUSTRY	
Maryland		P.G.		Lanham		YES <input checked="" type="checkbox"/>		9321 Calanda Street 20706		Lever Brothers	
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
Mansel				Manning		Margaret				McGaan	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
NO		289-36-5489		Joan Kodak (Daughter)		Same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anterior Wall myocardial Infarction</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> Year DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Alzheimer's disease</u>											
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) N/A							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 2/14/85		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>2/14/85</u> to <u>2/15/85</u> , 1985, that (I) we last saw the deceased alive on <u>2/14/85</u> , 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <u>Don H. Yablonowitz</u>		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/15/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Don H. Yablonowitz MD		22e. ADDRESS 10300 Greenbelt Rd., Seabrook, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/21/85		23c. NAME OF CEMETERY OR CREMATORIAL St. Joseph's Cemetery		23d. LOCATION CITY OR TOWN Cincinnati		COUNTY Hamilton		STATE Ohio	
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, Md. 20781						25a. DATE REC'D. BY REGISTRAR FEB 21 1985		25b. REGISTRAR'S SIGNATURE Julie Davidson Randle			

8307

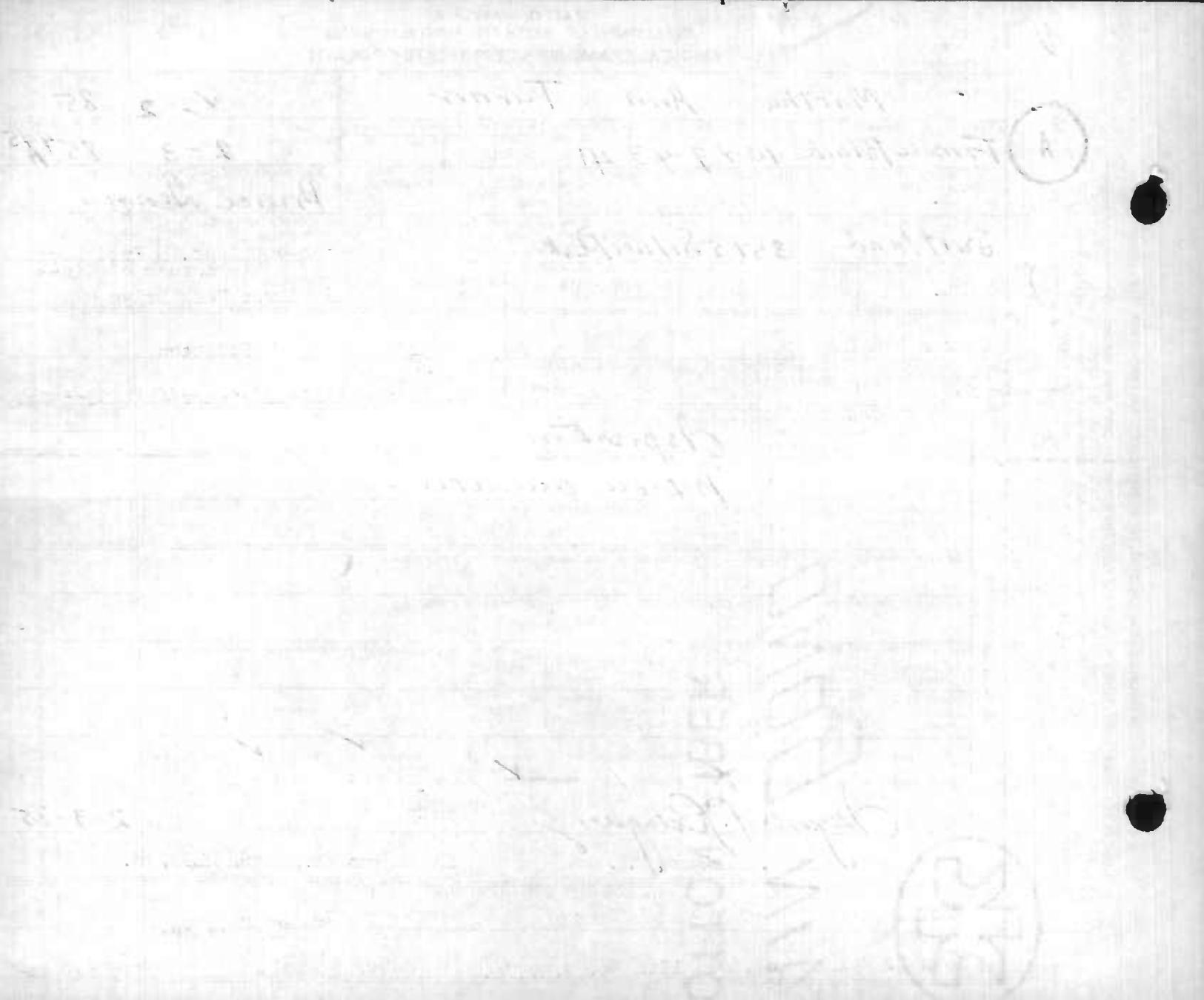
8307



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, AND 3 TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3, RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 06123							
1. DECEASED NAME (TYPE OR PRINT)			FIRST Martha			MIDDLE Ann			LAST Turner			2a. DATE KNOWN <input type="checkbox"/> MONTH 1985 OF ESTI- DEATH MATED 2-2 1985					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS MONTH DAY YEAR LAST BIRTHDAY)			7. IF UNDER 1 YR. <input type="checkbox"/> IF UNDER 24 HRS.					
Female			Black			10-19-43			41 yrs.			MONTHS DAYS HOURS MIN					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			2c. DATE PRONOUNCED DEAD 2-3 1985					
Va.			USA									Prince George			445 M		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Suitland			3515 Silver Park			Management Asst.			Bureau of Mines								
13a. STATE Md.			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 3515 Silver Park Drive					
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			LAST					
George Dunning									Lizzie			Stratton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No			223-54-6021			Ms. Susie Williams/sister/4116 32nd St.						Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aspiration</i> DUE TO <input type="checkbox"/> AS A CONSEQUENCE OF <input type="checkbox"/> Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) <i>in the audience</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY					
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/>									and in my opinion					
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>			TITLE (SPECIFY) M.D. Deputy			MEDICAL EXAMINER			DATE SIGNED 2-3-85								
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			5009 Rayburn Ct., Temple Hills, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY					
Burial			2-8-85			Family			Nelson Co., Va.			STATE					
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
John T. Rhines Co., 3015 12th St. N.E., Va.						FEB 5 1985			Lilia Davidson-Rhines								
DHMH - 17 (VR A15 ME (5))																	
20M 4/82																	



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BP

3/28/85 Released by DEPTMED, EX - Autopsia Rodriguez, M.D.  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										85 06124				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
IRA			F.	TUSING		FEB 28 1985						? A.M.		
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
MALE			WHITE		MONTH DAY YEAR AUG. 4. 1911			73			MONTHS	DAYS	HOURS	MIN.
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
VIRGINIA			U.S.A.					PRINCE GEORGES						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY					
BLADENSBURG			5103 TILDEN ROAD			BOILER MAKER-WELDER			RAILROAD					
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE					
MD.			PR. GEO.		BLADENSBURG		YES <input type="checkbox"/> NO <input type="checkbox"/>		5103 TILDEN ROAD 20710					
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			LAST					
			HENRY		TUSING	NOT AVAILABLE								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
NO			577-05-1249			LEWIS VIRGINIA TUSING			5103 TILDEN RD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
ACUTE MYOCARDIAL INFARCTION										MINUTES				
DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE										YEARS				
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
DIABETES MELLITUS														
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (1) (the physician) attended the deceased from NOVEMBER 19 80 to FEBRUARY 19 85, that (1) (the physician) saw the deceased alive on 2/27/85, and that in (my) (the physician) opinion death occurred on the date and hour and from the causes stated above, (1) (the physician) (did not) view the body after death.														
22b. SIGNATURE Marta Anne Schneider M.D.										DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 2/28/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			22f. BURIAL, CREMATION, REMOVAL (SPECIFY)			22g. DATE REC'D. BY REGISTRAR			22h. REGISTRAR'S SIGNATURE		
MARTA ANNE SCHNEIDER M.D.			5401 MACHARIAH BLVD. N.W. WASH. D.C. 20016			23a. DATE March 2. 1985			23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cemetery			23d. LOCATION Brentwood P.M. Md		
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Takoma Funeral Home, J. G. Schiller			254 Canal St. NW DC			MAR 1 1985			Julie Laidlow-Purcell					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 29 shows any injury, or other traumatic event, the medical examiner has been notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				85 06125		
REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
CHARLES	ANTHONY	ULLMAN		Feb. 9 1985	925 AM	
3. SEX MALE	4. RACE CAU.	5. DATE OF BIRTH MONTH DAY YEAR JAN. 30, 1909	6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.			
10. CITY OR TOWN OF DEATH CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION SOUTHERN MARYLAND HOSP. CTR.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER	12b. KIND OF BUSINESS OR INDUSTRY TOBACCO			
13a. STATE MARYLAND	13b. COUNTY CHARLES	13c. CITY OR TOWN WALDORF	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	14. FATHER'S NAME FIRST MIDDLE LAST CHARLES JOSEPH ULLMAN	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GRACE JOHANNA WINKLER	16. STREET ADDRESS / ZIP CODE Rt 2 Box 200, 20601
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. 812-16-7639A	17. INFORMANT MARGARET B. DUFFY, WALDORF, MD.	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC ADENOCARCINOMA OF PROSTATE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)	19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 YRS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). BILATERAL BRONCHOPNEUMONIA						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.) FEBRUARY 9 1985	21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>MARCH</u> 1984, to <u>FEBRUARY 9</u> 1985, that (I) (we) lost saw the deceased alive on <u>FEBRUARY 9</u> 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.	22b. SIGNATURE James A. Brown, MD	22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED 2/10/85			
22e. ADDRESS 8926 Woodland Rd CLINTON MD 20735						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 2-13-85	23c. NAME OF CEMETERY OR CREMATORIAL ST. JOSEPH'S	23d. LOCATION POMFRET, CHARLES, MD.			
24. FUNERAL DIRECTOR HUNTT FUNERAL HOME, WALDORF, MD.	25a. DATE REC'D. BY REGISTRAR FEB 14 1985	25b. REGISTRAR'S SIGNATURE Julia Davidson-Hampelle				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and retained by the hospital or attending physician, it should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene or to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as 'Yes', then Item 22a, 'Cause of Death', and Item 22b, 'Signature', must be completed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										Dr. Rodriguez notified.					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST EDNA			MIDDLE MAE			LAST VAN WERT			2a. DATE OF DEATH FEBRUARY 14, 1985		2b. HOUR M	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>August 1, 1924</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S</b>							
10. CITY OR TOWN OF DEATH <b>UpperMarlboro</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>9221 Goldenrod Lane</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sales Clerk, Private, Ret'D</b>			12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Pr. George</b>		13c. CITY OR TOWN <b>Upper Marlboro</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>9221 Goldenrod Lane 20772</b>							
14. FATHER'S NAME FIRST <b>JAMES</b>			MIDDLE <b>G.</b>		LAST <b>WOODS</b>		15. MOTHER'S MAIDEN NAME FIRST <b>BRIDE</b>			MIDDLE		LAST <b>BUCKLER</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>* * * 578-42-1491</b>			17. INFORMANT <b>Son, Mr. George A. Van Wert Jr., same as #13</b>			ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer of lung</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____															
DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____									
22a. I certify that (1) (the hospital) attended the deceased from <b>6-22</b> , 19 <b>84</b> , to <b>2-14</b> , 19 <b>85</b> , that (1) (we) last saw the deceased alive on <b>1-11</b> , 19 <b>85</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) (did not) view the body after death.										22c. DATE SIGNED <b>2-14-85</b>					
22b. SIGNATURE <i>William Kent Furst</i>			22c. DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William Kent Furst, M. D.</b>			22e. ADDRESS <b>11701 Livingston Rd., Ft. Washington, MD</b>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>February 16, 1985</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Suitland, P.G., Maryland</b>						
24. FUNERAL DIRECTOR NAME <b>LEE FUNERAL HOME, 6633 Old Alexander Ferry Road, Clinton, Maryland 20735</b>			25a. DATE REC'D. BY REGISTRAR <b>FEB 22 1985</b>			25b. REGISTRAR'S SIGNATURE <i>Davidson Pendell</i>									



## TO HOSPITAL OR ATTENDING PHYSICIAN. The

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be retained for use as the burial transit permit. Then please remove carbon paper. Faxes should be sent to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked or item 18 shows any injury, or other traumatic event, no medical examination is required.

MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8506121

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
Joseph (N.M.I.)			Vicino			February 26, 1985				6:53A
3 SEX	4. RACE	5. DATE OF BIRTH	MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR
Male	White	August 15, 1896			88	MONTHS		DAYS		IF UNDER 24 HRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH					
Brazil	U.S.A.	Prince George's County								
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY
Lanham	Doctor's Hospital of Pr. Geo. Co.					Ret. Shoemaker				Self-Employed
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE				
Maryland	P.G.	E. Riverdale	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			6119 62nd. Place 20737				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.				
FIRST Dominic	MIDDLE	LAST Vicino	FIRST Aquila	MIDDLE	LAST Mancuso	17. INFORMANT				
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			18b. SOCIAL SECURITY NO.			18c. ADDRESS				
No			577-48-0890			Mr. Dominic V. Vicino, Philadelphia, Md. 20783				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular hemorrhages acute</i> DUE TO, OR AS A CONSEQUENCE OF, (b) <i>atherosclerotic cardiovascular disease</i> Conditions, if any, which give rise to immediate cause (a), stating the underlying cause, if any. (c) <i>Stroke</i>										
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED  WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE
22a. I certify that (1) (this hospital) attended the deceased from July 31, 1981, to Feb. 26, 1985, that (2) we lost low the deceased alive on Feb. 26, 1985, and that (3) my (our) opinion death occurred on the date and hour and from the causes stated above. I have read and understood the body of death.										
22b. SIGNATURE <i>William D. Rosson</i>										
22c. DATE SIGNED Feb. 27, 1985										
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS							
William D. Rosson, M.D.			5701 85th. Ave. New Carrollton, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORI			23d. LOCATION CITY OR TOWN	23e. COUNTY	23f. STATE			
Burial	March 1, 1985	Fort Lincoln Cemetery			Brentwood	P.G.	Maryland			
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A.			ADDRESS Hyattsville, Maryland			25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE <i>Jeanne Davidson-Tendelle</i>
						FEB 28 1985				

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.								
1- STATE REGISTRAR			FIRST JAMES			MIDDLE WALKER			LAST WALKER			2a. DATE KNOWN OF ESTI- DEATH MATED	1 MONTH DAY YEAR	2b. HOUR						
1. DECEASED NAME (TYPE OR PRINT)			James			Walker						<input type="checkbox"/>	1-29 1985	15:00						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD	MONTH DAY YEAR	2d. HOUR				
Male		Black		Dec. 22, 1930			54 yrs.			MONTHS	DAYS	HOURS	MIN.	1-29 1985	15:00					
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
North Carolina			United States									Prince Georges								
CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION NOT IN SUCH FACILITY, GIVE STREET ADDRESS												12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince Georges General Hospital												Plumber			Construction (20743)		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? NO <input type="checkbox"/>			13e. STREET ADDRESS								
Maryland			Prince Georges			Capitol Heights						629 Capitol Heights Blvd.								
14. FATHER'S NAME			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME											
Johnny						Walker			Susie			Tucker								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			629 Capitol Hgts. Blvd. Capito.			ADDRESS								
No			237-50-0972						Beatrice Allen Walker (wife) Hgts. MD											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aspiration pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>Carcinoma of the esophagus</i> DUE TO, OR AS A CONSEQUENCE OF (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?					
															<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																				
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i> M.D. Deputy MEDICAL EXAMINER															DATE SIGNED <i>1-29-85</i>					
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 5009 Rayburn Ct., Temple Hills, Md.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 02/02/85			23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cemetery			23d. LOCATION CITY OR TOWN Brentwood, PG: Maryland			COUNTY STATE								
24. FUNERAL DIRECTOR NAME LATNEY's Funeral Home ADDRESS 3831 Georgia Avenue, NW; Washington, DC									25a. DATE REC'D. BY REGISTRAR FEB 13 1985			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendall</i>								
BP																				
DHMH - 17 (VR A15 ME (5))																				
20M 4/82																				



Release by Dr. Rodger

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						85 06129					
						REG. NO.					
1 - FOR STATE REGISTRAR	FIRST NAME (TYPE OR PRINT)	MIDDLE NAME	LAST NAME	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
	Vernie	E.	Walker	02	11	85		10:45 AM			
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS	8. IF UNDER 24 HRS HOURS MIN.		
Female	White	MONTH	DAY	YEAR	76						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Virginia	U.S.A.				Prince George's MD.						
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Clinton	Southern Maryland Hospital Center			Nurse			Medical				
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. STREET ADDRESS / ZIP CODE					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	2672 Pinewood Dr. 20601								
Maryland	Charles Co.	Waldorf	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. ADDRESS					
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME	FIRST	MIDDLE	LAST				
Elijah	Marion		Humphries	Mary	Elizabeth		Birch				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No	579-48-2654	Brenda Critzer			Respiratory failure						
19. DATE OF OPERATION						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 2-10, 1985, to 2-11, 1985, that (I) (we) last saw the deceased alive on 2-11, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						22b. SIGNATURE William K. Furst, M.D.			22c. DEGREE MD		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			22f. DATE SIGNED		
William K. Furst, M.D.						11701 Livingston Rd., Ft. Washington, Md.			2/12/85		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE	
Burial		2-14-85		Cedar Hill Cemetery		Suitland		Pr. Geo.		Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS		6160 Oxon Hill Rd.		13. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
George P. Kalas Funeral Home		Oxon Hill, Md.		FEB 14 1985		Julia Davidson Pendleton					

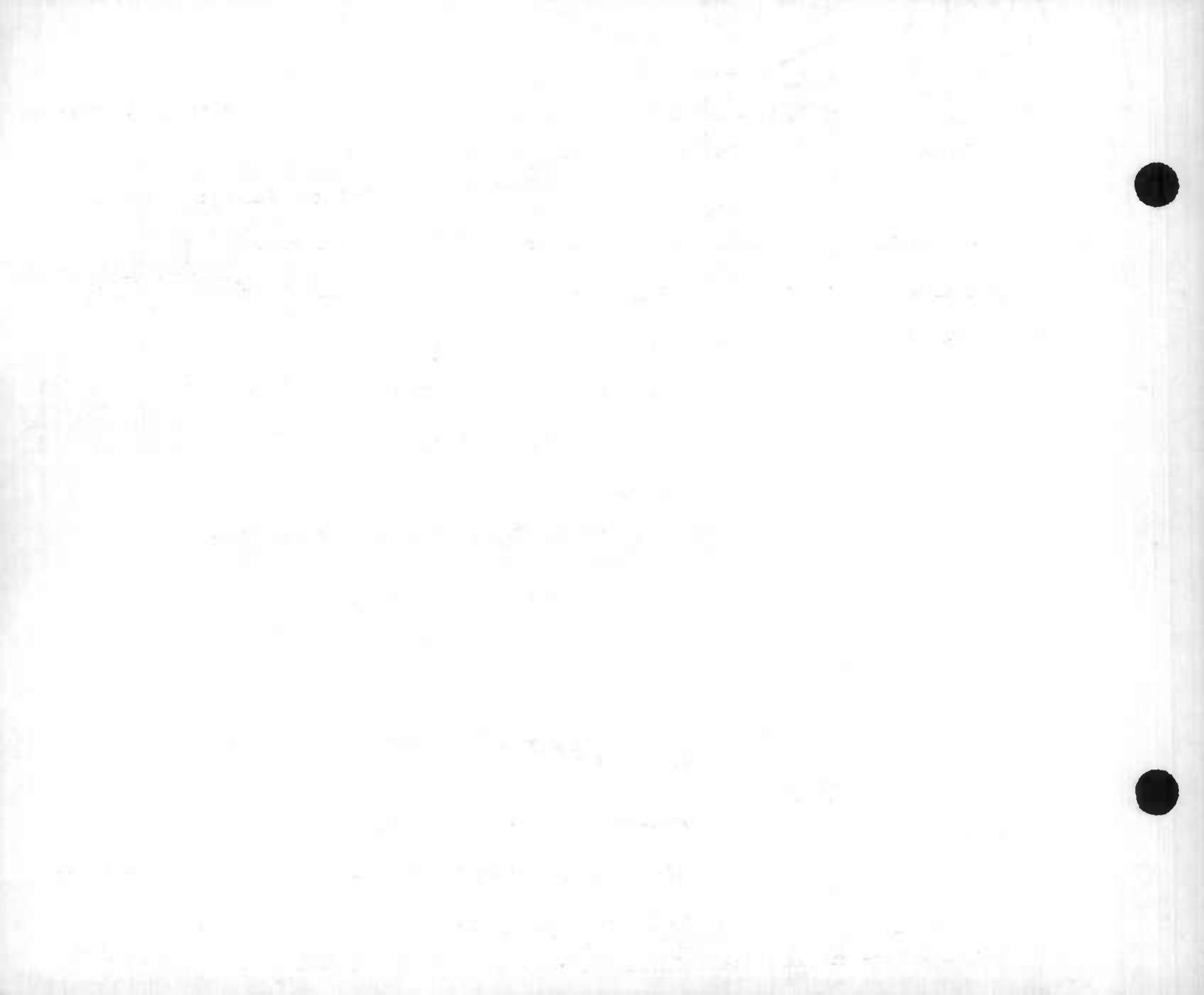


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon copies. Page 1 and 2 should be hand within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8506130	
												REG. NO.	
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR	
			EMILIA P. WARREN						FEB 11 1985			11:15 AM	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
FEMALE			CAUCASIAN			JULY 22, 1922			62				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.				
ITALY			U.S.A.										
10. CITY OR TOWN OF DEATH Camp Spring, MD			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grove Med. Center Andrews AFB			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY				
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Virginia			14. STATE Fairfax			15. CITY OR TOWN Falls Church			13a. STREET ADDRESS / ZIP CODE Falls Church, VA. 22044			3422 Barger Dr. 9:11 AM	
14. FATHER'S NAME Mattia			MIDDLE Pennacchia			15. MOTHER'S MAIDEN NAME Giacinto			16. ADDRESS John R. Warren Falls Church, Virginia 22044			LAST Patrizi	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 120-24-2002			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			(b) Sepsis										
			DUE TO, OR AS A CONSEQUENCE OF (c) Widely Metastatic Hypernephroma										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 28 Jan 1985 to 11 Feb 1985, that (I) (we) last saw the deceased alive on 11 Feb 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22b. DATE SIGNED 11 Feb '85	
22b. SIGNATURE John A. Engelmann						DEGREE MD			ATTENDING MEDICAL PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN A. ENGELMANN, MD			22e. ADDRESS MALCOLM GROW USAF MC ANDREWS AFB MD 20331										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 14, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Arlington National			23d. LOCATION CITY OR TOWN Arlington Co. Virginia			23e. DATE REC'D. BY REGISTRAR FEB 14 1985	
24. FUNERAL DIRECTOR Murphy Funeral Home Falls Ch. 1102W. Broad St.			ADDRESS Falls Church, VA. 22046									23f. REGISTRAR'S SIGNATURE Julie L. Rondell	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 3 days after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												85 06131	
REG. NO.													
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			VIOLA V. WEAVER						02 21 85			3 15A M	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female			White			October 23, 1908			76 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH	
Virginia			U.S.A.						PRINCE GEORGE'S COUNTY MD.			CHEVERLY	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			13a. STREET ADDRESS / ZIP CODE				
PGG HOSPITAL AND MEDICAL CENTER			Homemaker						5112 Kenilworth Ave. / 20781			13b. STATE Maryland	
13a. STATE Maryland			13b. COUNTY P.G. Co.			13c. CITY OR TOWN Hyattsville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. None			17. INFORMANT Charles B. Weaver (Husband) Same as # 13.	
			Virginia										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b)			Severe COPD			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Severe tracheal stenosis (2) Esophageal carcinoma (3) Scleroderma	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (# EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			YES <input type="checkbox"/> NO <input type="checkbox"/>				
22a. I certify that (1) (this hospital) attended the deceased from 2/20 19 85 to 2/21 19 85, that (1) (we) last saw the deceased alive on 2/20 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.												22b. DATE SIGNED 2/21/85	
22c. SIGNATURE Gerardo M. Gacad			22d. DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS 6492 Landover Rd. Landover MD							
22f. PHYSICIAN'S NAME (TYPE OR PRINT) GERARDO M GACAD													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb/23/85			23c. NAME OF CEMETERY OR CREMATORIAL St. Lincoln Cemetery			23d. LOCATION CITY OR TOWN Brentwood, P.G. Co., Maryland			23e. DATE REC'D. BY REGISTRAR FEB 2, 1985	
24. FUNERAL DIRECTOR NAME Chambers Funeral Home Riverdale, Maryland			ADDRESS									23f. REGISTRAR'S SIGNATURE Julia Davidson Pendell	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retooled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-tranport permit. Then please remove carbon paper. Pages 1 and 2 should be retained for removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified. Once

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8506132											
										REG. NO.											
1. FOR STATE REGISTRAR			2a. DATE OF DEATH							2b. HOUR											
I. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR						
Josephine REID WEBER										2a. DATE OF DEATH		2-17-85		645 P.M.	2b. HOUR						
3. SEX			4. RACE			5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS									
F			White			MONTH 10		DAY 17		YEAR 89		95		MONTHS YRS		DAYS HOURS MIN					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.											
Penn.			U.S.A							Prince Georges											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Hyattsville, Md.			Hyattsville MANOR							Housewife			Own Home								
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland			13b. COUNTY Pr. Geo.			13c. CITY OR TOWN Hyattsville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3318 Gumwood Drive 20783										
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST						
ALAN REID						REID			Florence						Reid						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.							17. INFORMANT			ADDRESS								
No			265-92-4297							Florence Widutis			3318 Gumwood Dr. Md., 20783								
18. CAUSE OF DEATH (Enter only one cause per line for item 1b, and 1c.)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (1a)										10 mts											
Cardio respiratory arrest																					
DUE TO, OR AS A CONSEQUENCE OF (b)										Arteriosclerotic heart disease 5 yrs											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b).																					
DUE TO, OR AS A CONSEQUENCE OF (c)																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																					
Cerebro vascular accident																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
										YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE								
22a. I certify that (I) (we) attended the deceased from saw the deceased alive on 2/17/85, to 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE Myron H. Henkin M			22c. DEGREE							ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Myron H. Henkin M			22e. ADDRESS 2309 Shortfield Road Heaton MD 20902																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Removal 2-18-85			23c. NAME OF CEMETERY OR CREMATORIAL Geo. Wash. U. Med. School		23d. LOCATION CITY OR TOWN Washington, D.C.		CITY OR TOWN		COUNTY		STATE							
24. FUNERAL DIRECTOR NAME			225 Missouri Avenue			ADDRESS		DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE John A. Wadsworth											
Columbia Mortuary Services WASH., D.C. 20011																					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 22 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8506133							
1 - FOR STATE REGISTRAR										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
BENJAMIN F. WILKERSON, III									2/16/85						3:54 AM		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS		
Male			Caucasian			MONTH October 9 YEAR 1937			47			MONTHS			DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			10b. KIND OF BUSINESS OR INDUSTRY		
North Carolina			U.S.A.						PRINCE GEORGES COUNTY MD.			Body Shop Mgr.			Toyota Automobile		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
CLINTON			SOUTHERN MARYLAND HOSP. CTR.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			20748					
13a. STATE Maryland			13b. COUNTY Prince George			13c. CITY OR TOWN Temple Hills			15. MOTHER'S MAIDEN NAME			16. ADDRESS			17. LAST		
14. FATHER'S NAME FIRST Benjamin			MIDDLE F.			LAST Wilkerson, Jr.			Madeline			5436 Old Temple Hill Rd.			Jordan		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			18. ADDRESS			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Yes			Korea			577-52-7864			Barbara A. Wilkerson			5436 Old Temple Hill Rd.			18 hrs		
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			18. DUE TO, OR AS A CONSEQUENCE OF (b) Influenza pneumonia			18. DUE TO, OR AS A CONSEQUENCE OF (c)			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			4 days					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 18.										Chronic lymphocytic Leukemia							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from saw the deceased alive on above, (I) (the hospital) did not view the body after death.										2-15 1985 to 2-16 1985, that (I) (the hospital) lost opinion death occurred on the date and hour and from the causes stated							
22b. SIGNATURE Thomas F. Cleary, M.D.			22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. ADDRESS 9131 Piscataway Rd., Clinton, Md. 20735			22e. DATE SIGNED 2-16-85								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 2/19/85			23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cemetery			23d. LOCATION CITY OR TOWN Brentwood			COUNTY P.G. Maryland			STATE		
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home			ADDRESS 6160 Oxon Hill Rd.			25a. DATE REC'D. BY REGISTRAR FEB 25 1985			25b. REGISTRAR'S SIGNATURE Laurelson Rendell								

1. Peer review of inner  
10. ~~and~~ ~~inner~~ ~~inner~~  
2. ~~and~~ ~~inner~~ ~~inner~~  
3. ~~and~~ ~~inner~~ ~~inner~~  
4. ~~and~~ ~~inner~~ ~~inner~~  
5. ~~and~~ ~~inner~~ ~~inner~~  
6. ~~and~~ ~~inner~~ ~~inner~~  
7. ~~and~~ ~~inner~~ ~~inner~~  
8. ~~and~~ ~~inner~~ ~~inner~~  
9. ~~and~~ ~~inner~~ ~~inner~~

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. RETAIN PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED IN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

1- STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

8 5 0 6 1 3 4

1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>George</i>	MIDDLE <i>A</i>	LAST <i>Williams</i>	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH <input checked="" type="checkbox"/>	DAY <input type="checkbox"/>	YEAR <input type="checkbox"/>	2b. HOUR <input type="checkbox"/> 2-6 1985 M		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	9c. DATE PRONOUNCED DEAD	MONTH <input type="checkbox"/> 2-6	DAY <input type="checkbox"/>	YEAR <input type="checkbox"/> 1985 A	2d. HOUR <input type="checkbox"/> 302		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George</i>						
10. CITY OR TOWN OF DEATH <i>Clinton</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Southern Maryland Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Sales</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Retail</i>			
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Pr George</i>		13c. CITY OR TOWN <i>Upper Marlboro</i>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>9201 Carendon Court 20772</i>				
14. FATHER'S NAME FIRST <i>Albert</i>		MIDDLE <i>Edward</i>		LAST <i>Williams</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Laura</i>		MIDDLE <i>Harper</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <input checked="" type="checkbox"/> Yes		16b. SOCIAL SECURITY NO. <i>WWII</i>		16c. ADDRESS <i>Unk</i>		17. INFORMANT <i>D. Yvonne Williams</i>		ADDRESS <i>Same as #13</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic pelvicic cancer &amp; vascular disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Chronic obstructive pulmonary disease</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								2d. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>		TITLE (SPECIFY) <i>Deputy</i>			M.D. MEDICAL EXAMINER							
DATE SIGNED <i>2-6-85</i>												
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS <i>5009 Rayburn Ct., Temple Hills, Md.</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>9 Feb 1985</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Cemetery</i>			23d. LOCATION CITY OR TOWN <i>Suitland</i>		COUNTY <i>PG</i>	STATE <i>Md</i>		
24. FUNERAL DIRECTOR NAME <i>Robert E. Wilhelm</i>		ADDRESS <i>Funeral Home</i>		25a. DATE REC'D. BY REGISTRAR <i>FEB 11 1985</i>		25b. REGISTRAR'S SIGNATURE <i>John Davidson Pendell</i>						
BP _____		DHMH - 17 (VR A15 ME (5)) 20M 4/22										



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												5 0 6 1 3 5		
												REG. NO.		
1- STATE REGISTRAR			2a DATE KNOWN OF DEATH ESTIMATED									2b. HOW		
1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			2b. DATE KNOWN OF DEATH ESTIMATED			2b. HOW		
Leigh G.			1981-11-25			1981-11-25			Feb. 28 1985 10 AM			M		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE IN YEARS (LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN	2c. DATE PRONOUNCED DEAD	MONTH DAY YEAR	2d. HOW		
M	W	Jan 13 21	64 yrs.							Feb. 28 1985	19 07	10 AM		
7a. BIRTHPLACE: STATE OR FOREIGN COUNTRY			7b. CITIZEN OF WHAT COUNTRY?									9. BALTIMORE CITY OR COUNTY OF DEATH		
Virginia			USA									Prince George		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Laurel			Greener Laure Bectu v. de Hoop									12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
Md.			Montgomery			Burtonsville			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			2086b Sandy Spring Rd		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES (YES, NO, OR UNKNOWN) (IF YES, GIVE RANK OR GRADE)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
Jack Williams			Nora Sealock			WW 2			218 09 7807			Shirley Williams as above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF												10 days		
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) <i>Chronic Myocardial Disease</i> DUE TO, OR AS A CONSEQUENCE OF												Yrs		
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
20. MEDICAL CERTIFICATION			21a. DATE OF OPERATION None			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21c. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21d. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21e. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
21g. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21h. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												22b. TITLE (SPECIFY) M.D. <i>John Rogers</i> MEDICAL EXAMINER		
23a. EXAMINER'S NAME (TYPE OR PRINT)												23b. DATE SIGNED <i>March 1, 1985</i>		
JOHN ROGERS														
23c. ADDRESS			23d. LOCATION CITY OR TOWN <i>Burtonsville, Maryland</i> COUNTY STATE											
23e. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23f. DATE <i>March 4, 1985</i>			23g. NAME OF CEMETERY OR CREMATORIUM <i>Union Cemetery</i>			23h. DATE REC'D. BY REGISTRAR <i>MAR 07 1985</i>			23i. REGISTRAR'S SIGNATURE <i>Julia E. Wilson-Rogers</i>		
24. FUNERAL DIRECTOR NAME Donaldson Funeral Home, Laurel, Maryland														

2000 ft. 30 min

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 21a shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										5 5 0 6 1 3 6							
1. FOR STATE REGISTRAR			2a DATE OF DEATH							REG. NO.							
I. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST			MONTH	DAY	YEAR	2b. HOUR				
NADINE ALYSSA WILLIAMS										Feb.	1	1985	FEB 5 1985 4:00 p.m.				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS (LAST BIRTHDAY))			IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS			
Female			Black			MONTH DAY YEAR Feb. 1, 1985			YRS.			4		4			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Prince George's County MD.		
Maryland			U.S.A.			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Andrews A.F.B. Camp Springs			Malcolm Grow USAF Hospital			None			None			None					
13a. STATE Maryland			13b. COUNTY P.G. Co.			13c. CITY OR TOWN Forestville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 6561 Hill-Mar Drive 20747					
14. FATHER'S NAME FIRST Bruce			MIDDLE -			LAST Williams			15. MOTHER'S MAIDEN NAME FIRST Robin			MIDDLE F.			LAST Washington		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No			None			Bruce Williams 572 MP Co. Ft. Ritchie, Md.									Cardiorespiratory arrest		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						PROBABLE SEPTIC SHOCK									Probable Septic Shock		
(b)																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from 1/26 1985 to 15 Feb 1985, that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Mark J. Rollo			22c. DEGREE						22d. DATE SIGNED Feb. 5, 1985								
22e. PHYSICIAN'S NAME AND QUALIFICATION Mark J. Rollo			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb/11/85			23c. NAME OF CEMETERY OR CREMATORIAL Maryland Veterans Cem.			23d. LOCATION CITY OR TOWN Cheltenham, P.G. Co., Maryland			23e. COUNTY		STATE			
24. FUNERAL DIRECTOR NAME Chambers Funeral Home Silver Spring, Maryland			25a. DATE REC'D. BY REGISTRAR FEB 13 1985						25b. REGISTRAR'S SIGNATURE John K. Rollo								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached for use as the burial-trust permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8506137						
					REG. NO.						
1 - FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR					
NELSON		N	WILLIAMS	Jr.	FEB 3 1985	2317pm					
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
Kentucky		U.S.A.		MAY 13 1928		56					
8. YRS.		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.									
10. CITY OR TOWN OF DEATH Andrews A.F.B.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grose Medical Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attorney		12b. KIND OF BUSINESS OR INDUSTRY Legal				
13a. STATE Maryland		13b. COUNTY Pr. George		13c. CITY OR TOWN Ft. Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 203 Creighton Circle 20741			
14. FATHER'S NAME FIRST Will		MIDDLE Noah		LAST Williams		15. MOTHER'S MAIDEN NAME FIRST Elsie		LAST Bogges			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. Retired 1977		17. INFORMANT Ruth Williams		ADDRESS Same as item 13					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE <input checked="" type="checkbox"/>		Cardiopulmonary Arrest								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF Myocardial Infarction									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>23 Jan 1985</u> to <u>3 Feb 1985</u> , that (I) (we) lost soul the deceased alive on <u>3 Feb 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Donald W. Rrumbaugh</u>		22c. DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD W. Rrumbaugh, CAPT, USAF MC		22e. ADDRESS MALCOLM GROW USAF MED CEN ANDREWS AFB MD2033		22f. DATE SIGNED 2/4/95							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-7-1985		23c. NAME OF CEMETERY OR CREMATORIAL Resurrection Cemetery		23d. LOCATION CITY OR TOWN Clinton		COUNTY P.G.		STATE Md.	
24. FUNERAL DIRECTOR NAME G.P. Kalas F.H.		ADDRESS 20745 6160 Oxon Hill Rd. Oxon Hill, Md.		25a. DATE REC'D. BY REGISTRAR FEB 7 1985		25b. REGISTRAR'S SIGNATURE <u>Davidson Pendell</u>					
VRA 15, 4)											

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hundred

per

100

of which the first 100 were to be paid in 1860

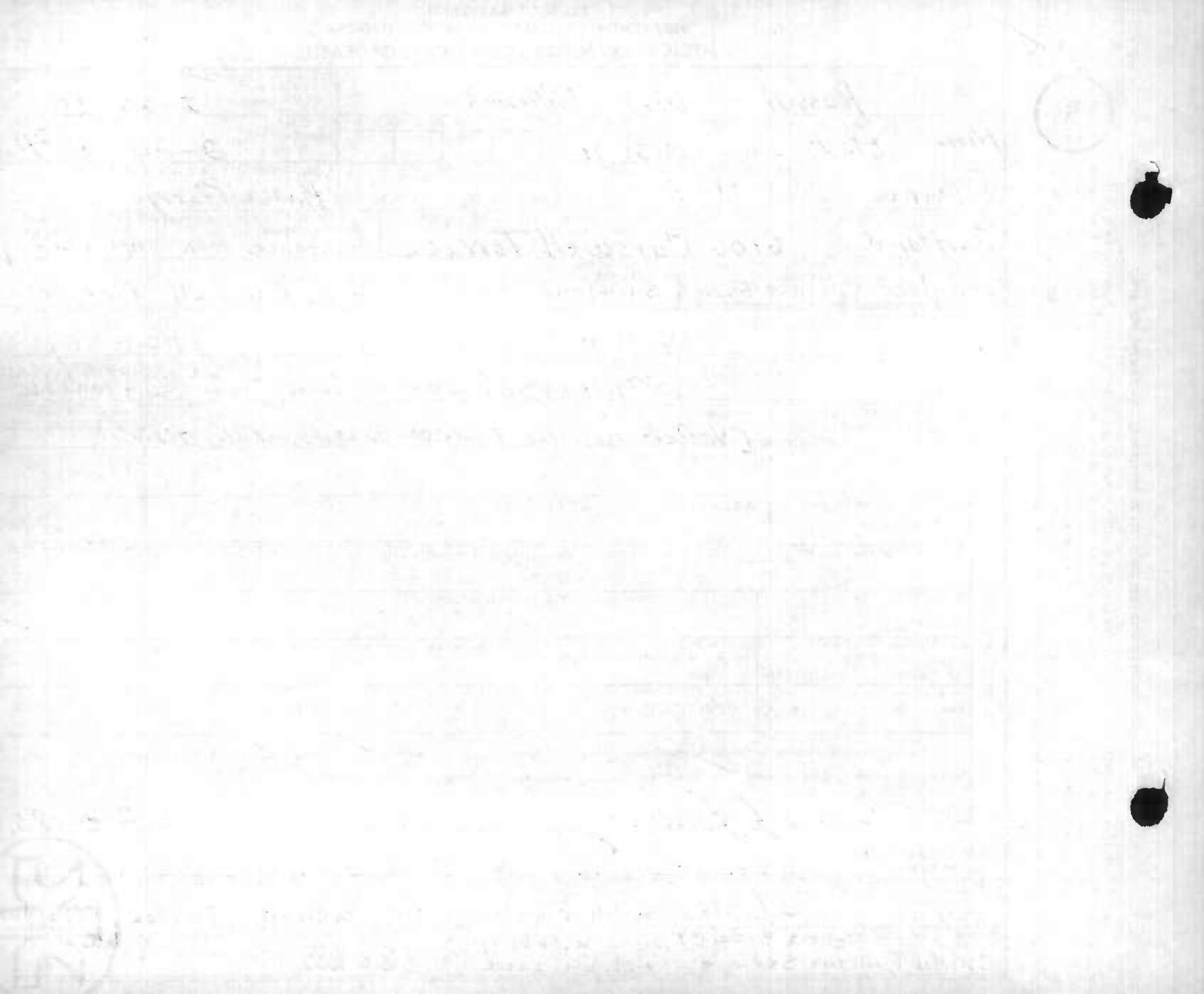
and

the remaining 100 in 1861

and so on for the remaining 100

0 6 1 3 8

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.				
1- STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			LAST			2a DATE KNOWN OF ESTI- MATED			2b. HOUR				
			Russell W. Wilson Williams						2-20 1985			M				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD		2d. HOUR		
Male		Black		June 5, 1913		71 yrs.						2-20		T 9 85 30 M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges							
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges						MD.							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Suitland			6106 Carswell Terrace			Mantance Man			Apt Building							
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		20746					
Maryland			Prince George		Suitland				6106 Carswell Terrace							
14. FATHER'S NAME			15. MOTHER'S M AIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT				
David			Victoria			NO			579-18-8372A			Gloria Coates - Sister				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART I DEATH WAS CAUSED BY:			6106 Carswell Terrace			PART I DEATH WAS CAUSED BY:			6106 Carswell Terrace							
IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF			IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause lost.			DUE TO, OR AS A CONSEQUENCE OF			(b)			DUE TO, OR AS A CONSEQUENCE OF							
(c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			19c. DATE OF OPERATION			20. AUTOPSY?							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY				
												STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																
22b. TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER																
22c. EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.																
22d. ADDRESS 5009 Rayburn Ct., Temple Hills, Md.																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 2/23/85			23c. NAME OF CEMETERY OR CREMATORIAL Shiloh Bapt. Church Cem.			23d. LOCATION CITY OR TOWN McLean			COUNTY STATE Fairfax, Virginia				
24. FUNERAL DIRECTOR NAME Robert B. Baker			ADDRESS 2605 20th Street, Shirlington, VA 22206			25a. DATE REC'D. BY REGISTRAR FEB 22 1985			25b. REGISTRAR'S SIGNATURE John Davidson							
Chinn Funeral Service																
BP																
DHMH - 17 (VR A15 ME (5))																
20M 4/B2																



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, REVERSE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1M. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 prior to BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												5	0	6	1	3	9
												REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN <input checked="" type="checkbox"/> EST. MONTH DAY YEAR		2b. HOUR			
Richard			Michael			Williamson, III			2/16/1985		M						
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Oct 4, 1956		6. AGE (IN YEARS LAST BIRTHDAY) 28 YRS.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 2/16/1985		9. MONTH DAY YEAR 9:30 P.M.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD											
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Service Attendant		12b. KIND OF BUSINESS OR INDUSTRY Unknown											
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Ft. Washington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9001 Rollingwood Dr. 20744									
14. FATHER'S NAME FIRST Richard		MIDDLE M.		LAST Williamson, Jr.		15. MOTHER'S MAIDEN NAME FIRST Louise		LAST Howard									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-68-4201		17. INFORMANT Mr. Richard M. Williamson, Jr. /father		ADDRESS same as 13e		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Narcotism DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?											
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion														
ACTUAL SIGNATURE <i>Dennis F. Smyth, M.D.</i>			TITLE (SPECIFY) Assistant			MEDICAL EXAMINER			DATE SIGNED 2/17/85								
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.			ADDRESS 111 Penn St.														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2-21-85			23c. NAME OF CEMETERY OR CREMATORIAL Cheltenham			23d. LOCATION CITY OR TOWN Cheltenham			COUNTY Md.					
24. FUNERAL DIRECTOR John T. Rhines Co., 3015 12th St. N.E., D.C. 20007						25a. DATE REC'D. BY REGISTRAR 2-21-1985			25b. REGISTRAR'S SIGNATURE <i>Davidson-Randall</i>								
07/84 25M		BP		DHMH - 17 (VR A15 ME (5))													



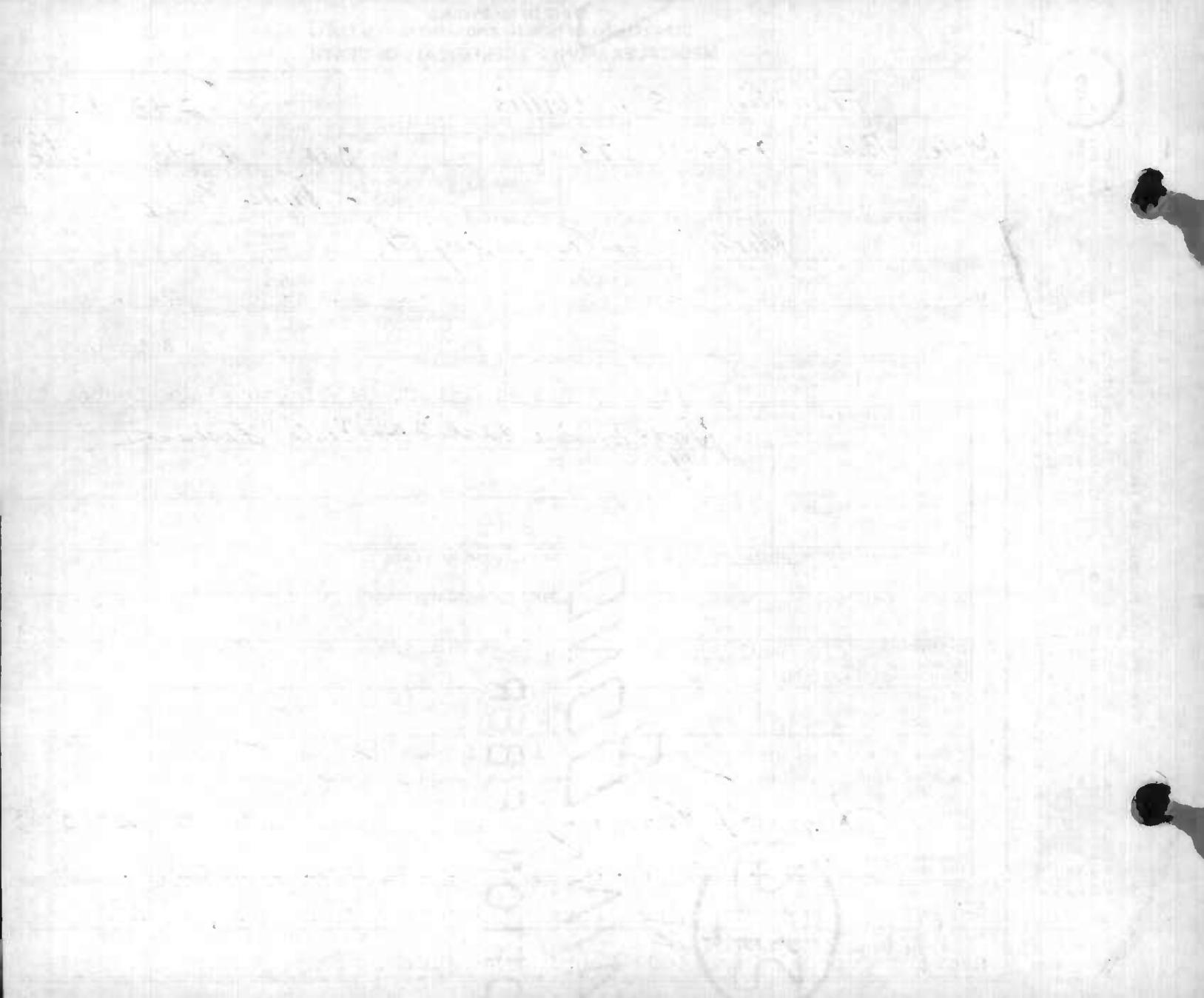
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8 5 0 6 1 4 0

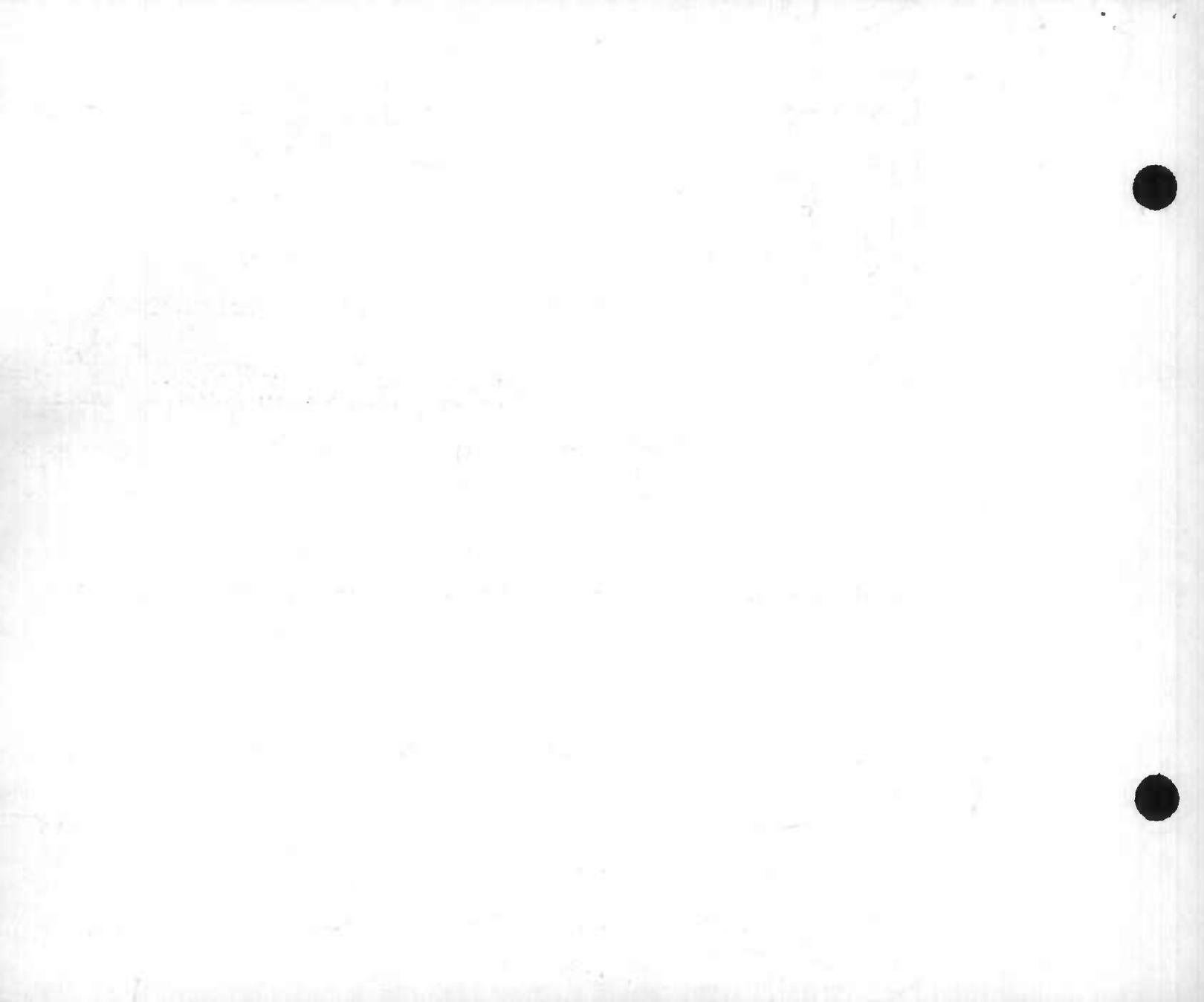
REG. NO.

1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH DAY YEAR	2b. HOUR		
Franklin S. Willis						<input type="checkbox"/>			2-13 1985			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS	9. MONTHS	10. DAYS	11. HOURS	12. MIN	13. HOUR		
Male	Black	9-16-11	73 yrs.							2d HOUR		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH			
Pittsburg, Pa			USA			<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			Prince Georges			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
			Baltimore General Hospital			Retired			20743			
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			
Maryland			P.G.			Chapel Oaks			YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST			LAST			
Frank			E.			Sarah			L. Johnson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
no			163 12 8114			Ralph C. Willis-son-1409 Dunbar Oak						
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive Cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
(b) DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
						<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion						
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>						TITLE (SPECIFY) M.D. Deputy			MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			5009 Rayburn Ct., Temple Hills, Md.			DATE SIGNED <i>2-13-85</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			
Burial			Feb. 18, 1985			Harmony Memorial			Park Landover, Md.			
24. FUNERAL DIRECTOR NAME <i>John T. Stewart</i>			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Stewart Funeral Home-4001 Benning Road						FEB 21 1985						







TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. PAGE 1 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM BM. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE												5	0	6	1	4	2			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- MATED		MONTH	DAY	YEAR	2b. HOUR			
Vander			Edward			Wood			Jr.			<input checked="" type="checkbox"/>		2	19	85	M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	2d. HOUR	
Sept 10, 1928		56 yrs.										2		19		85	11:15 p.m.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH P.G.								
10. CITY OR TOWN OF DEATH Clinton			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center DOA			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dispatcher (R)			12b. KIND OF BUSINESS OR INDUSTRY Transit Co.											
13a. STATE Virginia			13b. COUNTY			13c. CITY OR TOWN Charlottesville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 409 Arbor Circle			99999-22901						
14. FATHER'S NAME FIRST Vander E. Wood, Sr.			15. MOTHER'S MAIDEN NAME FIRST Daisy																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WII & Korean 228-26-5980			17. INFORMANT Mary A. Wood			ADDRESS 409 Arbor Circle Charlottesville, Va. 22901											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF																				
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u>																				
(b) _____ DUE TO, OR AS A CONSEQUENCE OF																				
(c) _____																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?														
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																				
ACTUAL SIGNATURE 												TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER				DATE SIGNED 2/20/1985		
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.			ADDRESS 5009 Rayburn Ct., Temple Hills, Md 20748																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 25, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Monticello Mem. Gardens			23d. LOCATION CITY OR TOWN Charlottesville			COUNTY		STATE						
24. FUNERAL DIRECTOR NAME Cunningham Funeral Home			ADDRESS Alex., Virginia			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE Julia Davidson-Bondale											
BP DHMH - 17 (VR A15 ME (5)) 20M 4/82																				



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

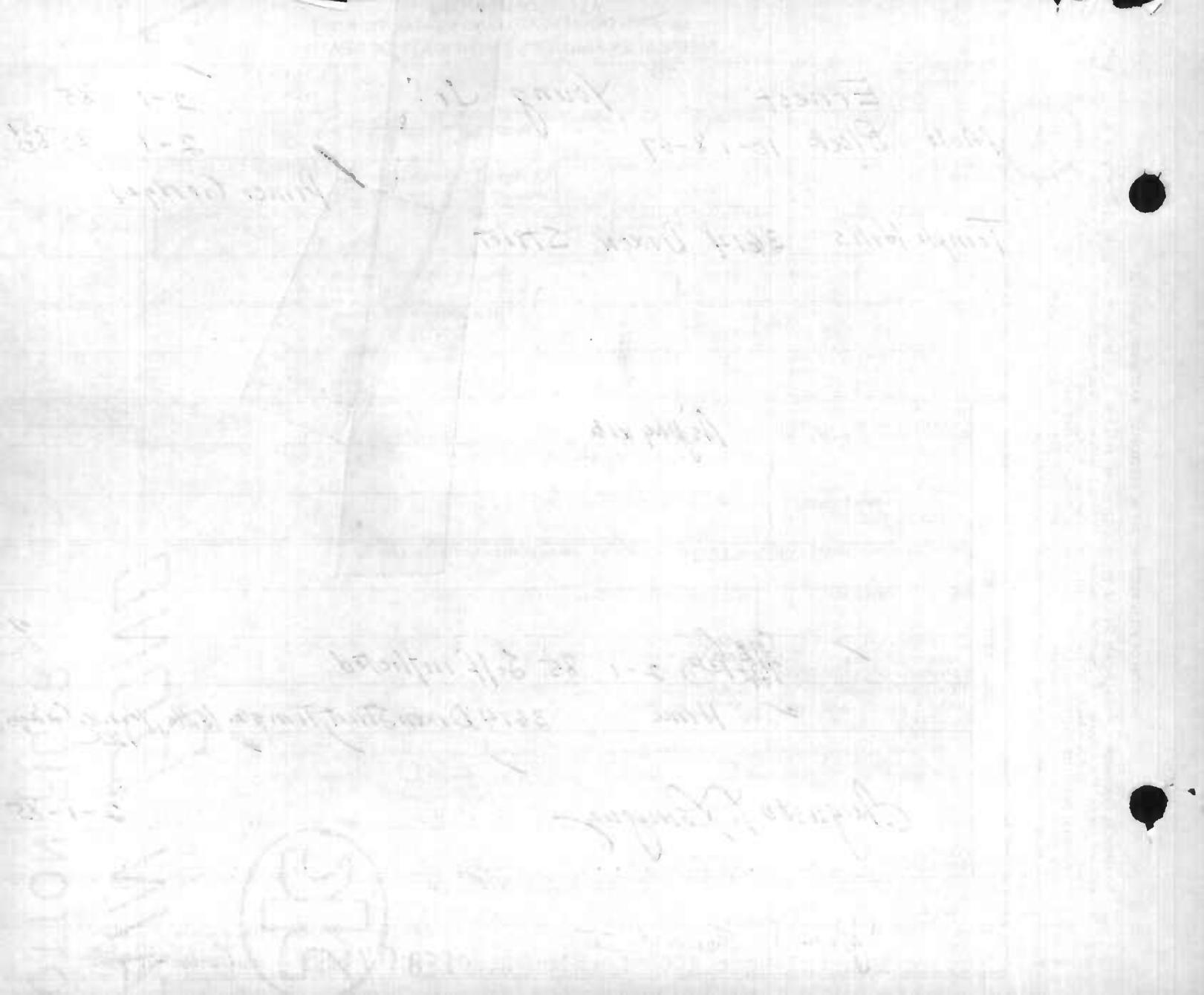
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8 5 0 6 1 4 3						
1. DECEASED NAME (TYPE OR PRINT)			FIRST WILLIAM			MIDDLE E			LAST YEAGER			2a. DATE OF DEATH 02 19 85		MONTH	DAY	YEAR	2b. HOUR 3:40 P.M.	
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH March 26, 1942			YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 42		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS HOURS MIN.		
7a. BIRTHPLACE COUNTRY Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.						
10. CITY OR TOWN OF DEATH CHEVERLY			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSP			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Construction			12b. KIND OF BUSINESS OR INDUSTRY									
13a. STATE Md.			13b. COUNTY St. Mary's			13c. CITY OR TOWN Hollywood			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rt. 1, Box 320A 20636							
14. FATHER'S NAME FIRST Elmer			MIDDLE			LAST Yeager			15. MOTHER'S MAIDEN NAME FIRST Catherine		MIDDLE Estelle			LAST Rollins				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 224-54-3386			17. INFORMANT Carolyn M. Yeager, Same as 13e.			ADDRESS									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRAIN DEATH												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												(b) INTRA CEREBRAL HEMATOMA DUE TO RUPTURE MIDDLE CEREBRAL ANEURYSM						
DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 219			21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (this hospital) attended the deceased from 3/12/85 to 2/19/85, that (I) (we) last saw the deceased alive on 2/19/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 2-21-85						
22b. SIGNATURE SAIED JAMSHIDI, M.D.						DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SAIED JAMSHIDI, M.D.						22e. ADDRESS 6172 OXON HILL RD. OXON HILL, MD 20745												
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial			23b. DATE 2/23/85			23c. NAME OF CEMETERY OR CREMATORIAL Charles Mem. Gdns.			23d. LOCATION CITY OR TOWN Leonardtown, St. Mary's Md.			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE						
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley, Leonardtown, Md.			ADDRESS															
25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE FEB 25 1985, Julia B. Bostick, R.N.																		



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1(b) AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR VITAL RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 REPORT TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												5 06144									
												REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED			2b. MONTH	DAY	YEAR	2b. HOUR			
Ernest						Young Jr.						<input checked="" type="checkbox"/> 2-1 1985									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS) <input type="checkbox"/> UNDER 1 YR. <input type="checkbox"/> IF UNDER 24 HRS.			7. LAST BIRTHDAY MONTHS DAYS HOURS MIN.			2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR
Male			Black			10-18-67			16 yrs.						<input type="checkbox"/> 2-1 1985						
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			8b. CITIZEN OF WHAT COUNTRY?			8c. MARRIED <input type="checkbox"/> NEVER MARRIED			8d. WIDOWED <input type="checkbox"/> DIVORCED			8e. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Washington, D.C.			USA			<input checked="" type="checkbox"/>			<input type="checkbox"/>			Prince Georges									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY												
Temple Hills			3614 Dixon Street			Student															
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS									
Maryland			P.G.			Temple Hills						3614 Dixon Street			20146						
14. FATHER'S NAME			FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME									
Ernest									Young, Sr.			Walter Ruth Anderson									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS												
no			219 02 9306			Ernest Young, Sr. - father - 3614 Dixon															
18. CAUSE OF DEATH (Enter only one cause per line for (b), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asphyxia</i>												STREET, TEMPLE HILLS, MARYLAND									
DUE TO, OR AS A CONSEQUENCE OF																					
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.																					
(b) _____ DUE TO, OR AS A CONSEQUENCE OF																					
(c) _____																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			19c. DATE			20. AUTOPSY?												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			19c. DATE			20. AUTOPSY?												
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21d. LOCATION												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION			21g. STATE												
22a. I certify that I took charge of the remains described above, held an			Autopsy <input type="checkbox"/>			Inspection <input type="checkbox"/>			Inquiry <input type="checkbox"/>			and in my opinion									
death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>			TITLE (SPECIFY) Deputy			M.D.			MEDICAL EXAMINER			DATE SIGNED <i>2-1-85</i>									
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			5009 Rayburn Ct., Temple Hills, Md.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			STATE									
Burial			Feb. 6, 1985			Lincoln Memorial Cemetery			Suitland			Maryland									
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE															
John T. Stewart, III																					
Stewart Funeral Home 4001 Benning Road			Feb. 07, 1985			John Davidson-Randall															
BP _____																					
DHMH - 17 (VR A15 ME (5))																					
20M 4/B2																					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene for burial, cremation, or removal.

INFO/DETAN: If Item 21 is marked on Item 18, state any injury, or other traumatic event, the medical examiner must be informed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8506145						
										REG. NO.						
1. FOR STATE REGISTRAR			2a. DATE OF DEATH							2b. HOUR						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	MONTH			DAY	YEAR						
Edmund			Eugene	Zacharias		August			20	1985	5am M					
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR					
male			white		MONTH DAY YEAR			71			IF UNDER 24 HRS					
7a. BIRTHPLACE (COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8			MONTHS DAYS			MONTHS DAYS HOURS MIN.					
Maryland			USA		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			YRS.			YRS.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Laurel			1700 Brooklyn Bridge Road							manager			paint distrib-			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
13a. STATE Maryland			13b. COUNTY P. G.		13c. CITY OR TOWN Laurel			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 1700 Brooklyn Bridge Road 20707					
14. FATHER'S NAME FIRST			MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST			LAST					
Otto			Duker		Zacharias			Maria			Eugenia Hoffecker					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
yes			WW 2		213 12 1966A			Iva Zacharias			same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										Bones are fractured						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										Due to, or as a consequence of (b)						
Due to, or as a consequence of (c)										Concussions of the face, mouth						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE BERT L. HARRIS, M.D. F.D.A. DR. Peter Sherry -			DEGREE			22c. DATE SIGNED 2/23/85										
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>																
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ELBA J. MARTINEZ, M.D.			22e. ADDRESS 8808 HIDDEN HILL RD. - POPLAR, MD.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Feb. 23, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Westview Mem. Park			23d. LOCATION CITY OR TOWN Catonsville, Md			COUNTY STATE				
24. FUNERAL DIRECTOR NAME Donaldson Funeral Home, Laurel, Md			ADDRESS			25a. DATE REC'D. BY REGISTRAR MAR 04 1985			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall							

